

11.0 Medicare and Medicaid Payments for Improved Nurse Staffing: Issues and Options¹

11.1 Overview and Approach

11.1.1. Overview

The amount of money that nursing homes have to spend on staffing and other necessities is heavily dependent on public payment systems.² This chapter summarizes some key issues and options for policy-makers' consideration in the event that new minimum nurse staffing standards are to be established and policy-makers want to pay for the new mandate appropriately.

The cost for public payers and the effect of new requirements and accompanying payments depends on programmatic design details. This is illustrated well by the different results of different approaches to estimating the potential cost of new minimum staffing requirements, discussed elsewhere in the report. In one approach, the cost of paying for adequate staffing is computed independently and then compared to what Medicare is currently paying for the nursing component of Medicare rates. That analysis suggests that a new minimum could be cost free to Medicare, if adequate payments for meeting minimums were the only issue. Another analysis estimates the cost of bringing all nursing homes up to a new minimum staffing level, regardless of what homes are already getting in Medicare rates — that is, the cost of all the “missing staff” is first computed and then a share of that cost is allocated to Medicare. That approach suggests increased Medicare costs of roughly \$6 Billion for nursing home payments. A key difference between the two is that the second assumes that Medicare would supplement existing payments with an “add-on” sufficient to pay for “missing staff,” regardless of the adequacy of current rates. The choice between those two payment approaches is one of the most contentious that policy makers face at the state and federal levels.

Decisions about that and similar issues require policy-makers to strike an appropriate balance among competing objectives: spending sufficient money (both in rates and administrative costs) to achieve staffing objectives; reasonable cost containment; administrative feasibility; and equity. Equity is a particularly complex issue. It involves federal state relationships in

¹ This chapter was written by Barbara B. Manard, Ph.D., of The Manard Company, Chevy Chase, Maryland, under a consulting agreement with Abt Associates.

² In 1998, Medicaid paid for the care of 68 percent of residents and Medicare paid for 9 percent. Twenty-three percent paid privately (including about 2 percent who have long-term care insurance). For further details about the relationship between public spending, different approaches to setting Medicare and Medicaid rates, and nurse staffing, see Chapter 2 in HCFA, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Summer 2000.

general; equity among states with regard to any new federal funds (e.g., should states that have financed higher staffing levels for years get less of any new money than states that have lower staffing rates?); accountability and commitments to residents, taxpayers, and providers. There is considerable discussion in provider trade publications (and some in scholarly journals) suggesting various approaches that should be tried to improve staffing levels in a tight market and/or make more efficient use of current staff, but relevant systematic program evaluations with national application are not available to help guide policy-makers choices.

11.1.2 Approach

The issues discussed below incorporate information from interviews with knowledgeable people representing a range of perspectives and experience.³ Two sets of interviews, focused information gathering, and analysis were conducted for this report.

The first round of interviews was conducted in November and December of 2000 (subsequently called “late 2000”). During this first round of interviews and discussions, respondents were assured that their remarks would not be referenced by name; rather, it was explained, the goal was to assemble, understand, and synthesize the full range of issues and options, to the extent possible.

A second (more limited) set of interviews and information collection activities was conducted in July through September 24, 2001. In that case, respondents were asked to provide information that would be attributed to them or the organizations they represent. The primary goal of those activities was to try to understand similarities and differences among a set of organizations’ positions at one particular point in time.⁴

³ Those interviewed included: staff from The American Health Care Association, The American Association of Homes and Services for the Aged, and The National Citizens Coalition for Nursing Home Reform; representatives of The Alliance for Quality Nursing Home Care, which is composed of 12 national long term care companies; additional nursing homes executives; and Medicare and Medicaid officials with experience in relevant operational and policy issues.

⁴ Those from whom information was obtained (and included in this chapter) during the second round (July through September 23, 2001) are specified in subsequent sections. Originally, this second round or phase was to include the analysis of some detailed information from five states (California, Florida, Minnesota, Texas, and Vermont) regarding their experience designing, implementing, and operating (for approximately 6-18 months, depending on the state) special programs to enhance staffing in nursing facilities and paid for as a special part of the Medicaid payment system. The timeline for this report’s activities, including the deadline for its completion, precluded completion of the original plan. As the timeline for this report developed during 2001, interviews and other information collection activities became scheduled mostly for the first two weeks of September 2001; to follow the August period of generally reduced staff availability in most state and other organizations. The events of September 11 substantially affected this plan. Further, during the preceding week, a set of events unfolded that necessarily occupied the time of many state officials and others concerned with federal/state policies regarding nursing facilities (cf: R. Pear, “U.S. May Ease Regulation of Nursing Home Industry,” *The New York Times on The Web*, 7 September 2001, accessed at 7 a.m. ET; The Associated Press, “White House Won’t Ease Nursing Home Rules,” *The New York Times On The Web*, 7 September 2001, AP report filed at 12:12 p.m. ET, accessed at 12:30 p.m. ET).

11.2 Paying Appropriately for Nursing Staff in the Context of Overall Rates

Nursing staff account for less than half of overall nursing home costs. Theoretically, it should be possible to determine a reasonable amount to pay for appropriate nursing staff, assuming that the two sides of that equation (prices and quantity) could be determined. Issues regarding setting appropriate public rates, looking at nursing in isolation, are discussed below. But at the outset it is important to recognize the interplay between spending on nursing staff and other items (food, other staff, capital and so fourth). If rates for appropriate nursing are paid adequately, but rates for other components are not, is it appropriate for providers to skimp on other costs such as food and pharmaceuticals that may be equally important to quality? In the alternative, should providers be expected to raise private pay rates to make up for shortfalls? On the other hand, if Medicare and Medicaid rates for nursing are inadequate, but some other rate components are substantially in excess of “reasonable” costs, should public payers pay the full cost of raising nursing rates to an adequate level, without considering opportunities for conserving aggregate public funds by reducing rates for other components?

If the answer to the question above is that public payers should pay “appropriately” for the “reasonable costs” of nursing home care in total, as most seem to agree in theory, the challenge of figuring out the cost of paying appropriately for nursing (assuming new minimum staffing standards) gets back to fundamental issues of nursing home rate setting that Medicare and Medicaid have been struggling with since the inception of the programs: determining payments that appropriately balance the competing objectives of reasonable cost-containment, quality, and access. If federal policy-makers decide to implement new staffing requirements, then the need to consider appropriate payments for nursing in the context of overall rates raises a set of issues specific to Medicare payments, and others related to federal oversight of Medicaid rates.

11.2.1 Medicare Rates

Key Issues Raised in Late 2000 by a Broad Range of Stakeholders and Public Officials

With regard to setting Medicare rates, the issues raised by those interviewed in late 2000 centered on concerns about trying to implement new staffing requirements (with appropriate payments for the nursing component) when there are substantial outstanding issues regarding Medicare’s new all inclusive pricing system in general. If, for example, the nursing component of the rates were set to reflect new concepts regarding appropriate staffing, could that be done equitably in a cost-efficient way without first reexamining the appropriateness of payments for therapies, ancillaries, and other components? If the appropriateness of the nursing component were to be determined--as in the first-cut cost estimates in following

chapters, by multiplying the number of “appropriate” nursing staff by wages, should that approach also be used to test Medicare’s prices for therapies and drugs?⁵

Some argued that a component-by-component detailed analysis is needed. Others preferred that only the adequacy of the nursing component be examined. Still others adamantly contended that Medicare should not reopen the whole concept of the new PPS pricing system; that the underlying premise of that payment system is similar to a negotiated price: Medicare offers to pay a particular price, for a defined set of services; providers are free to participate or not. The adequacy of the proffered prices should be tested against access and quality — optimally eventually measured by outcomes, at least at a future date — but for now determined by compliance with existing regulatory standards. Texas’ approach to its new program to increase nursing home staffing offers an interesting compromise position in which providers can *choose* between two different rates: one with less accountability and fewer requirements, the other (higher) rate with greater accountability.

Key Issues and Positions, Selected Stakeholders, September 2001

This is the first of three sections that address attributed concerns, policy positions, and analytic support for those positions of four major national organizations: The National Citizens’ Coalition for Nursing Home Reform (NCCNHR),⁶ The Alliance for Quality Nursing Home Care (The Alliance),⁷ The American Association of Homes and Services for the Aging (AAHSA),⁸ and The American Health Care Association (AHCA).⁹ The views of other important groups such as labor unions and professional organizations for those who work in nursing facilities were not assembled in this phase due to time constraints.

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- ⁵ An alternative approach to testing the adequacy of rates in general or individual rate components is used in some states. Instead of trying to build a “model nursing rate” by multiplying staffing hours by wages, these states compare their rates to case-mix adjusted nursing expenditures for homes that meet standards.
- ⁶ NCCNHR “was formed because of public concern about substandard care in nursing homes,” and seeks “to represent the consumer voice at the national level” (<http://www.nccnhr.org>).
- ⁷ The Alliance is composed of 12 national long-term care companies. These include several of the nation’s large multi-state for-profit companies such as Beverly Enterprises, Genesis Health Ventures, Sun Healthcare, Manor Care, and Harborside. The Alliance does not appear to have a WEB site of its own, but works closely with AHCA on several initiatives. Some information (with references to original sources) about The Alliance and its collaboration with AHCA can be found at a WEB site maintained by The Annenberg Public Policy Center of the University of Pennsylvania (<http://www.appcpenn.org>). Additional information, dated July 2001 and apparently based principally on a speech given by Michael Walker (Chairman of Genesis Health Ventures and Chairman of the Alliance), can be found at a WEB site maintained by an organization (MDSI) “with the singular focus of providing valuable and useable information to the distribution and marketing community involved in serving primary, acute, and longterm care markets” (<http://www.medicaldistribution.com>).
- ⁸ AAHSA “consists of more than 5,600 not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community service organizations” (<http://www.aahsa.org>).
- ⁹ AHCA “is a federation of 50 state health organizations, together representing nearly 12,000 non-profit and for-profit assisted living, nursing facility, and subacute care providers....” (<http://www.ahca.org>).

Information regarding NCCNHR's positions was obtained from the organization's WEB site.¹⁰ Information from the three associations representing nursing facilities was obtained by email.¹¹ Footnotes after each organization's name in this section list the documents relied upon for this and each subsequent section where these organizations' identified views are presented.

Three facts about the summaries presented below should caution the reader's reliance on those summaries alone for information regarding these organizations' positions:

- all four organizations have voluminous materials in the public domain, such as testimony before Congress, advertisements in various media, and numerous speeches presented across the country;
- three of the organizations (The Alliance, AHCA, and AAHSA) supplied requested summaries to highlight key positions in few days, during a national crisis, and the fourth organization (NCCNHR) was not contacted personally in this round to follow-up on previous discussions, due to this project's timeline; and
- finally, time did not permit the usual opportunity for those who supplied the source documents to review this author's summary of them.

Thus, it is best to view the summaries to follow as *one initial* comparison, subject to change as positions are clarified and evolve. The strength of the attempt, despite the limitations, lies principally in the outline of the issues (from the late 2000 discussions) exemplified and illuminated by specific points and counter-points.

With respect to Medicare rates:

- **NCCNHR¹²**
 - has said "The greatest weakness in [the Nursing Home Reform Law passed in 1987] was, and remains, the lack of a meaningful staffing standard";
 - has noted that while "reimbursement levels are a significant determinant of providers' ability to deliver optimal care," the organization;

¹⁰ <http://www.nccnhr.org>, accessed September 15, 2001.

¹¹ In late September 2001, the three major organizations representing nursing facilities responded to the author's request for written statements they might have or chose to prepare that would highlight their key concerns, policy positions, and the like regarding nursing facility staffing and public payments. In each case, the requests were sent as follow-ups to the same association staff that had participated in (or organized) earlier discussions (late 2000) with this chapter's author. Respondents were sent copies of documents or written summaries of comments from the previous (late 2000) discussions prior to the September 2001 exchanges.

¹² Various documents found at <http://www.nccnhr.org/govpolicy>.

- remains skeptical of “excuses given by the industry for not achieving the staffing needed to provide for residents.” NCCNHR particularly; and
 - dismisses the argument that bankruptcies following introduction of the new Medicare SNF PPS provide evidence that Medicare rates are inadequate, pointing out “Even homes in bankruptcy are staying in the business – just reconfiguring their shifting leadership – taking full advantage of the protections the bankruptcy laws allow.”
- **AAHSA¹³**
 - has focused recent comments regarding Medicare rates and staffing principally on details such as the inflation factor (arguing for continuation of the full market basket update beyond its scheduled reduction).
 - **AHCA¹⁴**
 - Stressed three key points regarding public payments and staffing minimums in September 2001:
 - First, collaboration among all parties: “Government, consumer advocates and providers must join together” to accomplish various goals, which AHCA refers to as creating ‘a fully-funded aggregate optimal staffing standard for nursing facility patients.’ Similarly, AHCA states it is impossible to “overemphasize the importance of all parties working together to address this critical issue.”
 - Second, maintain the Medicare SNF provisions that increased rates in 1999(BBRA) and 2000 (BIPA). Many call these provisions the “Medicare give-backs.” Certain key provisions and “give-backs” are due to expire soon. AHCA noted “If CMS does not act administratively and/or Congress legislatively on or before October 1, 2002, Medicare PPS rates to skilled nursing facilities will fall [substantially]. Indeed, continued inaction will soon

¹³ Email (September 19, 2001) from Ruta Kadnoff on behalf of AAHSA to Barbara Manard, reconfirming positions in a previous (November 9, 2000) document, supplemented with two more recent issue briefs; AAHSA, *Issue Brief: Long Term Care Workforce* (focuses on legislatively-oriented initiatives); AAHSA, *The Long-Term Care Workforce* (one page statement of the problem with proposed administrative and legislative solutions).

¹⁴ Email (September 21, 2001) from Rick Abrams on behalf of AHCA to Barbara Manard urging that the CMS report to Congress contain recommendations on three specific issues; AHCA, *Position of the American Health Care Association on Staffing Standards in Nursing Facilities* (summarizes position supporting “the creation of an aggregate optimal staffing standard” and offers five “guiding principles on the creation and maintenance of nursing facility staffing standards”).

create unease in the financial marketplace to the great detriment of the patients we serve and to providers.”

- Third, address “the historic and chronic under funding of Medicaid” payments for nursing facilities.
- **The Alliance¹⁵**
 - noted in late 2000 (and reaffirmed the position in September 2001) that it has “gone on record supporting staffing standards,”
 - focused principally on issues such as Medicaid and workforce availability issues (discussed in sections to follow), and
 - stressed that policy-makers should consider Medicare rates and staffing issues in the context of over-all market conditions: “There is real price sensitivity in the private pay marketplace, and contrary to popular opinion, the margins on private pay patients have been decreasing.”

In late 2000, the issues raised by those interviewed centered on concerns about trying to implement new staffing requirements (with “appropriate” payments for the nursing component) when there was such debate and contentiousness regarding Medicare’s new all-inclusive pricing system in general. The new payment system was the main event; staffing and quality were the supporting cast in many providers’ issue analyses. Today, however, many who once focused foremost on Medicare’s part in nursing facility bankruptcies, now put quality and staffing out front, with potential disruptions to owner’s aspirations as secondary considerations.

AHCA and The Alliance have become particularly visible — via a national ad campaign among other activities — in their collaborative effort to garner support for “aggregate minimum staffing ratios,” by focusing attention on a recent report by the General Accounting Office (GAO) which attempts to estimate the magnitude of a potential workforce shortage in nursing facilities in future years.

Regardless of which organizations or providers are more (or first) concerned about quality relative to dollars, it is important to tease out some of the key issues beneath current positions. These positions may shift; further, perceptions of positions are frequently reshaped deliberately — or unexpectedly, as changing circumstances refocuses the nation’s policy lens.

¹⁵ Email (September 19, 2001) from Linda Keegan on behalf of The Alliance to Barbara Manard, reaffirming positions in a previous document (December 2000) and summarizing 5 points.

One such underlying issue is the relationship between the market capitalization (stock prices) of publicly traded nursing facilities and quality care from a patient's perspective. To what extent is it true that unease in the capital markets would cause harm to patients? Despite dramatic declines of stock prices (and many bankruptcies) following the implementation of the new SNF PPS, there were not — according to GAO, the Inspector General (IG), or the industry itself — concomitantly dramatic, observable, negative consequences for patients.

Similarly, during the remarkable escalation of nursing facility valuations in the years prior to the SNF PPS, there does not appear to have been a concomitantly remarkable escalation of nursing facility quality, however measured.

11.2.2 Medicaid Rates

Key Issues Raised in Late 2000 by a Broad Range of Stakeholders and Public Officials

With respect to Medicaid rates, the repeal of the Boren Amendment in 1997 substantially reduced federal involvement in determining the appropriateness of Medicaid rates both prospectively in terms of federal review and approval of State Plans and as an issue subject to contest in federal courts. But the prospect of mandating new federal staffing standards raises again questions regarding the appropriate role of the federal government in assuring that sufficient, but not excessive, Medicaid money is available to pay for the quality of care that federal rules prescribe. Some providers interviewed were concerned that even if the federal government set new payment standards for the nursing component of state Medicaid rates, Medicaid rates for other components would in many cases still be inadequate.

State policy-makers interviewed for this project were more skeptical regarding the asserted inadequacy of their overall rates given current requirements, but they were universally concerned that new staffing minimums not be implemented as “unfunded mandates,” and urged that federal policy-makers provide both sufficient funds (perhaps through an enhanced federal match for nursing staff) and leave states sufficient flexibility to determine how Medicaid nursing homes rates should be set.¹⁶ Several Medicaid officials noted that declining nursing home occupancies present them with new opportunities to buy more services from less costly providers, while focusing on efforts to enhance the supply of alternative services and compliance with federal rules in the wake of the Olmstead decision. Given the wide range of circumstances across the states with respect to current Medicaid

¹⁶ Several Medicaid officials raised concerns about the challenge of coordinating and properly allocating staffing requirements and costs attributable to Medicare versus Medicaid patients. They noted that while it was frequently asserted that Medicare payments subsidize Medicaid underpayments (because Medicare payments have been generally more generous than Medicaid), the introduction of Medicare's new payment system has altered the dynamics in many states and created pressure for states to assume the cost of what some argue are shortfalls in Medicare payments. In addition, some State policy officials say that the combination of Medicare's new pricing system and the cost-related Medicaid payment systems used in most states has created new incentives for providers to maximize the portion of costs assigned to Medicaid on cost reports; they are wary of additional monitoring costs added to these they already see as the result of changes in Medicare policy.

rates, current costs, and local labor market issues, several State Medicaid officials suggested that the best — and perhaps only — way to gauge the cost of a new federal staffing requirement for Medicaid would be for states themselves to develop cost estimates with supporting documentation and program implementation proposals, in exchange for supplemental funding. But others were just as wary as providers of new reporting mechanisms and urged that at a minimum there be an adequate testing period under real world conditions.

Key Issues and Positions, Selected Stakeholders, September 2001

The format of this section replicates that regarding specific positions on Medicare rates. As noted, the sources for quotations and information attributed to each organization below are given in the section on Medicare rates above.

- **NCCNHR**

- stresses quality issues — as seen by its members and constituency — first, and secondarily emphasizes firm accountability systems for both Medicare and Medicaid rates. Thus, the organization
- remained largely neutral during the debates preceding repeal of the Boren Amendment — concerned that Medicaid spending on nursing facilities might decline, but unconvinced that law actually protected residents' quality of care.

- **AAHSA**

- has proposed a new federal requirement, much stronger than the Boren Amendment. The proposal was developed after late 2000 and appears potentially to sharpen some differences between AAHSA and the other provider organizations (AHCA and The Alliance). The proposal calls for:

“Funding to Improve Staffing: Recognize full labor costs under the Medicaid program by establishing a federal requirement that states incorporate 100 percent of labor costs for recruiting, training, retaining and compensating qualified staff as part of their Medicaid payment rates....The provision should also prohibit states from reducing funds to other components of their payment methodology to fund the newly recognized costs.”

- That provision differs from The Alliance and AHCA in that it would require state Medicaid programs and Medicaid-certified providers to maintain sufficiently detailed cost reports to determine the “full labor costs” that states would be required to fund. By contrast, The Alliance and AHCA have supported elimination of nursing facility cost reports and propose other ways (discussed later) for states and the federal government to establish “accountability” for nursing facility payments.

- **AHCA**

- consistently cites Medicaid payments as a major problem and a key barrier to appropriate staffing in nursing facilities;
- recently released a study it commissioned that reported that in all but one of the 36 states studied, Medicaid rates were lower than actual (allowable) facility spending on Medicaid patients in nursing facilities.

- **The Alliance**

- said “The Medicaid program is so severely under funded that simply addressing the incremental costs associated with a new staffing minimum will be sorely inadequate....Our companies simply cannot absorb the costs of the costs of additional federal staffing standards [in light of current losses on Medicaid] and shifting those costs to Medicare or to privately paying patients is not an option.”
- In support of the proposition that Medicaid rates are inadequate for even current costs, The Alliance cited a “recent work Joe Lubarsky has done for AHCA on Medicaid cost coverage [i.e., the document attributed to the accounting firm — BDO Seidman — in which Mr. Lubarsky is a partner, entitled *A Briefing Chartbook on Shortfalls in Medicaid Funding for Nursing Home Care*, August 30, 2001].
- The Alliance noted in late 2000--and underscored in September 2001 — the need to pilot-test any new staffing standard; it recommended the development of “a research framework...to ensure that these pilots surface the major policy issues” at both the state and federal level, and “allow us to measure the impact of higher staffing levels on care outcomes and on regulatory compliance.”

AHCA’s support for the development of the database used in the BDO Seidman study provides an opportunity to address numerous critical questions regarding the adequacy of Medicaid rates. Many studies in the past have relied on statewide aggregate “average rates,” to examine issues regarding both trends in the adequacy of Medicaid spending and the relationship between Medicaid rates and various measures of quality and/or access. Studies frequently have relied on such data, because that data is all that has been available for cross-sectional national studies or national trend analyses. Some important questions that could be addressed with the AHCA-supported data-base include these:

- To what extent is low occupancy a factor in the difference between Medicaid rates and costs in the newly available study? In the Phase I Report for this staffing study, researchers described an analysis of Ohio data in which declining occupancies accounted for virtually all of the a decline in per-diem cost-coverage. But national data have not been available before to determine whether Ohio is a relatively isolated

case, or whether in states such as Texas — with one of the lowest occupancy rates in the nation — the per-diem losses might be substantially mitigated and the problem viewed in a different light, were the costs adjusted for an efficient occupancy rate.

- Where are the real problems in the difference between payments and spending — are differences worse (or better) in the direct care components or property?

The answers to questions like those, combined with the analyses already made available, could give policy-makers at the federal level information critical to evaluating the need for and alternative designs for proposed federal programs addressing Medicaid rates.

11.3 Workforce Supply, Wage Rates, and Public Payment Costs

Those interviewed in late 2000 and those contacted again in September 2001 agreed that multiple staffing factors contribute to good (or poor) care and that implementing minimum staffing levels would be neither easily accomplished (as an administrative matter) nor likely to produce only the best *intended* results. Thus, this section does not distinguish between issues raised in late 2000 and those raised by specific organizations in September 2001.

Many of those we interviewed were concerned that regardless of the prices public payers might be willing to pay, there is an underlying shortage of RNs. Thus, if more RNs (who take time to train) were not first “produced,” mandating new RN standards for nursing homes would simply drain them from other health care sectors. Others believe that in the short term at least, RNs could be found, but only for a substantially higher price than current wages.¹⁷ Some urged that econometric analyses be done to estimate the incremental wages and benefits that would be required to draw RNs and potential CNAs into the workforce before trying to estimate the price to build into payments. Others suggested that it would be wise to invest first in labor-force development and/or to begin with a period of demonstrations and pilot projects in selected states before mandating new staffing levels to test hypotheses regarding how much it might cost (both for actual rate enhancements, when warranted, and for program implementation and monitoring efforts). Most suggested that program rules should provide for exceptions where good faith efforts to hire required staff did not succeed due to labor shortages.

By contrast, some argued that understaffing in nursing homes requires immediate attention, and that excessive testing could result in needless delays. Those supporting this position argue that a “best shot” program first be implemented nationally, and subsequently refined as problems are identified. The argument for this approach is that by the time the research is completed, the situation will have so substantially changed that major program adjustments will be needed regardless. Asked to respond to this suggestion, several Medicaid officials

¹⁷ Those interviewed suggested that 20-30 percent of any new RN hires would likely be contract agency nurses, though there was considerable variation in these rough-cut estimates. The cost of agency RNs was said to be anywhere from 20 percent higher to more than double the usual wages for on-staff nurses.

and providers said that a “fire first, aim later” approach would likely have to start out with higher public payments than minimum estimates to have any chance of success garnering sufficient support for the program — much like Medicare initially set managed care rates purposely high to develop participation. There was, however, general agreement that any new staffing requirement and concomitant changes to payments be closely monitored and subject to well-designed evaluations.

11.4 What Level of Staffing Should Be Built into “Appropriate” Public Payments?

Three issues dominated discussions on this topic with those interviewed in late 2000. First, respondents stressed the importance of pegging any new minimum staffing requirements to a measure of patient acuity (case-mix) that could be readily constructed from routine data available to providers. That is, if new staffing standards are required and are related to patient acuity (as most argue they should be), then providers need to be able to determine readily whether they are in compliance.¹⁸ As discussed in the Phase I report, this study approaches the issue of appropriate staffing quite differently from that used in developing the RUG-III classification system. If the resulting staffing minimums are tied to a different case-mix measurement system, respondents urged policy-makers to give considerable attention to efforts to harmonize the two.

Second, assuming that case-mix measurement issues are resolved, issues remain regarding the level of staffing that should be built into appropriate public payments. There was general agreement that if staffing minimums are set at the point related to avoiding bad outcomes, adequate payments should be pegged to a higher level of staffing. In addition, several public officials we interviewed were troubled by the notion of defining adequate payment for mandated staffing simply as the cost of new minimums, even if these were pegged to achieving good outcomes. These concerns arise because even the most refined case-mix measurement system will at best be an approximation of individual patients’ needs for nursing.¹⁹ To accommodate variations in “true need” for nursing at each facility (i.e., that not captured in the acuity-based minimum staffing requirements), some thus suggested picking a somewhat higher point for estimating adequate payments. That position was favored more by those who favor greater accountability for spending, recognizing the cost trade-offs in targeting public payments appropriately.

¹⁸ Policy-makers will also need to decide whether compliance with any newly mandated staffing ratios must be met every single day (like Vermont currently requires), or whether providers would have some leeway to meet standards on an aggregated (weekly or monthly, for example) basis.

¹⁹ That is, the actual nursing care needs for patients at a particular facility may vary considerably from the average predicted by even a refined case-mix measurement system. In the Phase I report we noted that it is difficult for surveyors to operationalize current staffing regulations effectively, which is one of the strong arguments in support of minimum staffing ratios. Nevertheless, some policy officials noted, so long as those additional general requirements remain, “adequate” public payments need to be determined in light of those overarching requirements.

The trade-offs that policy-makers have to consider stem from the fact that the higher the public rates for nursing, the higher the public cost, unless higher nursing care rates are balanced by cost savings elsewhere. Thus, considering the nursing cost component of rates alone, some prefer that the balance be achieved by pegging nursing care rates directly to new minimum staffing ratios (assuming these are set at the level for achieving good outcomes) and expecting providers to pay for those patients whose costs exceed predicted averages from savings achieved on patients whose costs are below average. Others prefer that public rates be set higher than the amount estimated for the new minimums, but that public costs for nursing care be constrained by minimizing opportunities for providers to profit on nursing rates. This issue would be moot (for Medicare, considered alone) if Medicare is already paying nursing rates sufficiently above the cost of new staffing minimums to allow for some staffing above the minimums, as the analyses discussed in a subsequent chapter suggest is currently the case (at least in the aggregate).

The third issue involves the use of the nursing times built into the RUG-III rates as an approach to testing the adequacy of Medicare rates for nursing. As discussed in a separate chapter, the research team found that current Medicare payments for nursing are less than costs when the staff times embedded in the RUG-III rates are multiplied by wage factors (though higher than the cost of the minimum staffing ratios discussed in the Phase I report). Respondents in late 2000 were divided regarding the appropriateness of that approach to testing the adequacy of Medicare's payments for nursing.²⁰ Some argued that the nursing minutes from the RUG-III system time studies are an implicit contract with providers to pay sufficiently for *those* minutes; they say that the minutes from the RUG-III time studies should in fact be the minutes built into actual payments. Others said that a key term in the actual implicit contract in the new payment system is providers' flexibility to decide whether or not to accept Medicare's offered price and--if they accept the price--to provide care meeting standards. From that perspective, Medicare need not consider either cost reports or RUG-III minutes in determining the adequacy of nursing payments; the test of adequacy should be tied to access and compliance with standards. The argument here is that it is fully appropriate for Medicare to offer a price that is in effect a discount off that calculated with RUG-III minutes in the equation.

The positions of NCCNHR, AAHSA, AHCA, and The Alliance on the final issue remained divided in September 2001, as discussed below. The debate above over approaches to testing the adequacy of Medicare rates is at heart a debate about "accountability." And in that issue lies the sharpest fissure dividing parties to the debate.

²⁰ Respondents were also divided on the matter of considering the adequacy of nursing component rates without also considering the adequacy (or possible excess over costs) of payments for other rate components.

11.5 Accountability

Two issues arise regarding approaches to accountability, should new minimum staffing requirements be required. Both have cost consequences, with the magnitude of those costs dependent on policy details. First, if new minimum staffing ratios are required, should there also be related new reporting requirements regarding staffing? Some advocates (prominently including NCCNHR) have long said that more detailed staffing information should be available to the public, regardless of whether or not new minimums are required.²¹

Second, to what extent (and how), should providers be held accountable for spending the money paid for nursing staff through public rates? Some argue strongly that if staffing is the issue, then only staffing should be tracked. That is, if new minimum staffing requirements are implemented, then providers need only be held accountable for having the staff required. The Alliance appears to be in this camp from its statement, reaffirmed in September 2001, regarding accountability: “We recognize that a ‘you spend it, we’ll sent it’ approach to payment is neither responsible nor advisable. But we also believe that it’s inadvisable to add more accountability systems to the systems that already exist. The current survey and enforcement system is designed to ensure that providers meet established standards. Use that system to ensure that standards are met, pure and simple.”

Others contend that in return for a new public commitment to pay for appropriate staffing, policy-makers have an enhanced fiduciary responsibility to taxpayers to better assure that public dollars actually are spent on nursing care. In many states, this has been the bargain struck between providers and those who determine rates (legislators and the executive branch). For example, each of the 5 states in the original design for this chapter has procedures for recouping funds from providers who fail to meet conditions specified in the staffing enhancement programs.

Accountability is more contentious with regard to Medicare than to Medicaid payments, because — as many see it — the fundamental contract between payers and providers in the new SNF payment system absolves Medicare from responsibility for detailed cost finding

²¹ If new staffing information were required, regardless of the reason, policy-makers will need to decide not only issues such as those discussed in a separate chapter (i.e., in what form and in how much detail should questions be asked and data reported), but also additional issues such as the frequency with which the new staffing data must be reported. There are a substantial number of operational details that optimally would be addressed *prior* to finalizing any proposed instrument’s design. Some states that were being tracked in the original design for this chapter, reported in preliminary interviews that the information needed for accountability with regard to their staffing enhancement programs is generally different from the form and frequency of information that might be most useful to consumers. Therefore, many providers and policy officials interviewed urged that the goals of any new staffing reports be carefully considered to minimize excessive additional reporting. That is, many expressed concerns that a form designed for one purpose (e.g., providing more information to consumers on a national WEB site maintained at the federal level) would be inappropriate for a different purpose (e.g., providing evidence that nursing facilities were actually staffing to the levels to which public payments were pegged, as required in a number of innovative state programs).

and matching of payments to expenditures on a facility-specific basis while providers are essentially free to keep any rewards from efficiently managing costs, so long as a provider remains in compliance with quality assurance regulations.

11.6 Conclusion

The most important point in this chapter for policy-makers is this: the cost for public-payers and the effect of new requirements and accompanying payments depends on programmatic design details.

If policy-makers at the state and/or federal levels want to estimate the cost of potential new staffing requirements, how should that be done? Costs for public programs will be higher if policy-makers choose to pay for all of the “missing staff,” regardless of whether there is already sufficient money in the rates to pay for the missing staff, were the money applied differently. Policy-makers might choose that more expensive option to further other goals such as minimizing the government’s role in directing provider spending. But policy-makers and others could benefit substantially from simulation models that allow ready evaluation of important trade-offs.

In addition, without an array of creative alternatives from which to choose, policy-makers might conclude that the only choices are the most extreme: a return to the earliest form of Medicare cost-related payments, or adding more money to the Medicare pricing system, in hopes that it will be spent wisely on staffing, if that is the intent. At present, states are experimenting with many different models and approaches to paying appropriately for improved nurse staffing. These initiatives might be studied, using simple techniques such as interviews, to help policy-makers learn rapidly what works in operational terms.